OSHA Form 200

U.S. Department of Labor

For Calendar Year 19____ Page ___ of ___

Company Name

Establishment Name

Establishment Address

Form Approved
O.M.B. No. 1220-0029

Extent of and Outcome of INJURY						Type, Extent of, and Outcome of ILLNESS											
Fatalities	Nonfatal Injuries					Type of Illness							Fatalities	Nonfatal Illness				
Injury Related	Injuries With Lost Workdays				Injuries Without Lost Workdays	CHECK Only One Column for Each Illness (*See other side of form for terminations or permanent transfers.*)							Illness Related	Illnesses With Lost Workdays				Illnesses Without Lost Workdays
Enter DATE of death. Mo./day/yr.	Enter a CHECK if injury involves days away from work, or days of restricted work activity, or both.	Enter a CHECK if injury involves days away from work.	Enter number of DAYS *away from work.*	Enter number of DAYS of *restricted work activity.*	Enter a CHECK if no entry was made in columns 1 or 2 but the injury is recordable as defined above.	Occupational skin diseases or disorders	Dust diseases of the lungs	Respiratory conditions due to toxic agents	Poisoning (systemic effects of toxic materials	Disorders due to physical agents	Disorders associated with repeated trauma	All other occupational illnesses	Enter DATE of death. Mo./day/yr.	Enter a CHECK if illness involves days away from work, or days of restricted work activity, or both.	Enter a CHECK if illness involved days away from work.	Enter number of DAYS *away from work.*	Enter number of DAYS of *restricted work activity.*	Enter a CHECK if no entry was made in columns 8 or 9.
(1)	(2)	(3)	(4)	(5)	(6)	(7)							(8)	(9)	(10)	(11)	(12)	(13)
						(a)	(b)	(c)	(d)	(e)	(f)	(g)						

Certification of Annual Summary Totals By _____ Title _____ Date _____

OSHA No. 200 POST ONLY THIS PORTION OF THE LAST PAGE NO LATER THAN FEBRUARY 1.

Bureau of Labor Statistics
Log and Summary of Occupational
Injuries and Illnesses

NOTE: This form is required by Public Law 91-596 and must be kept in the establishment for *5 years*. Failure to maintain and post can result in the issuance of citations and assessments of penalties. (*See posting requirements on the other side of form.*)

RECORDABLE CASES: You are required to record information about every occupational **death**, every nonfatal occupational **illness**, and those nonfatal occupational **injuries** which involve one or more of the following: loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment (other than first aid). (*See definitions on the other side of form.*)

Case or File Number	**Date of Injury or Onset of Illness**	**Employee's Name**	**Occupation**	**Department**	**Description of Injury or Illness**
Enter a nondupli-cating number which will facilitate com-parisons with supple-mentary records.	Enter Mo./day.	Enter first name or initial, middle initial, last name.	Enter regular job title, not activity employee was performing when injured or at onset of illness. In the absence of a formal title, enter a brief description of the employee's duties.	Enter department in which the employee is regularly employed or a description of normal workplace to which employee is assigned, even thought temporarily working in another department at the time of the injury or illness	Enter a brief description of the injury or illness and indicate the part or parts of body affected. Typical entries for this column might be: Amputation of 1st joint right forefinger; Strain of lower back; Contact dermatitis on both hands; Electrocution—body.
(A)	(B)	(C)	(D)	(E)	(F)
					PREVIOUS PAGE TOTALS
					TOTALS (Instructions on other side of form)